Insulin Safety Root Cause Analysis Paper

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Abstract

Manpower: Communication Clinical Manager example New Nurses afraid to speak up

Machines: Dual verification is type in an RN’s name

Your problem: Nurses not second verifying insulin which could lead to potential medication errors

Methods: By the book

Materials: Insulin being available in the Pixis
Insulin Safety Root Cause Analysis Paper

Double verifying insulin is a huge problem for nurses on the telemetry floor at Maryview Medical Center. Bon Secours requires the nurses to double verify insulin. On days that I work with my preceptor who trained me, I never have a hard time having my insulin double verified. Other days, the days that I call my “working with vulture” days, I have the hardest time verifying insulin for my patients. Within my fishbone diagram, I identified communication as the cause of the problem that could eventually lead to medication errors.

As a new nurse, I never thought doing it by the book would be a hard concept to do in nursing. I thought other nurses, especially seasoned nurses would want to do it by the book. I was wrong. My nursing instructor instilled in me that if you do it by the book you don’t have to remember how you did it for a particular patient. You did it by the book. Do it that way for everyone and you never have to question yourself how you did a particular procedure, you did it by the book. But on the telemetry floor there are problems to doing it by the book.

The Clinical manager would walk down the hallway, stating she was giving a patient 15 units of insulin and that is all she would do to verify insulin. Even the clinical manager thought she was above the system. This is an example of inappropriate management. When she would do this to me, I would cringe, because I did not verify the insulin she pulled, but I know she probably put my name down. When a floor has a clinical manager that is above the Bon Secours system, it promotes unsafe practices on the floor and creates an unsafe method within the telemetry floor environment. The American Society of Health-System Pharmacists discusses how institutions should put
individuals in roles that promote insulin administration (*Recommendations for Safe Use of Insulin in Hospitals*, 2004). Bon Secours requires the nurse to dual verify insulin, and even management is not above this protocol.

In American Nursing Today, it states: “Communication barriers should be eliminated and drug information should always be verified” (Anderson & Townsend, 2010). However, communication barriers are present on the telemetry floor. New nurses are afraid to speak up and seasoned nurses lay into new nurses who verify insulin. I was told by a seasoned nurse that if I didn’t know how to pull up two units of insulin I should go back to nursing school as she looked at me like she could cut me with a knife. She laughed at me and stated things that should not have been said to other employees. My question was for her to verify my two units of insulin for my patient, not how to draw it up. This promotes an atmosphere of unsafe practices.

It was hard thinking of a machine aspect for this insulin problem. If the insulin dosages had to be a dual sign-off like the heparin drip a nurse might not be more prone to type someone’s name in a slot. I often heard, you can use my name for any second verifications, “just type my name in”. If the nurses actually had to be there in the room to punch in their information, it’s possible that dual verification of insulin would actually happen.

Materials on the telemetry floor was an issue quite a few times because nurses would pull an insulin vial for each patient. When there are only two Lantus insulin vials on the floor and the nurses keep them in their pockets and won’t let you use them, it becomes a materials issue if more than two patients needs Lantus insulin. The materials issue could be easily addressed if insulin were dual verified, given right before
meals on a schedule and put back in the pixis.

Some nurses would say that load distribution and heavy workloads were a problem of dual verifying insulin. However, if the new nurse can have a heavy load and still honor the dual verification of the insulin administration, any seasoned nurse should be able to dual verify. It is harder to dual verify insulin when the load is distributed between two nurses, however, this is when you pull in the supervisors or any registered nurse (RN) walking down the hallway that is on duty. In the past, I have even dual verified insulin with the Bon Secours Nursing Supervisor of the facility, she was on the hallway that I was administrating medication at the time.

In conclusion, double verifying insulin is a huge problem for nurses on the telemetry floor at Maryview Medical Center. Bon Secours requires the nurses to double verify insulin. Within my fishbone diagram, I identified communication as the cause of the problem for dual verification of insulin that could eventually lead to medication errors. However, after writing this paper, it leads me to wonder if the root cause would be how the supervisor promotes communication and how the supervisor promotes dual verification for insulin.
References

